SECTION 8

Post-acute care

Skilled nursing facilities
Home health agencies
Inpatient rehabilitation facilities
Long-term care hospitals

Chart 8-1. Number of most post-acute care providers grew or remained stable in 2010

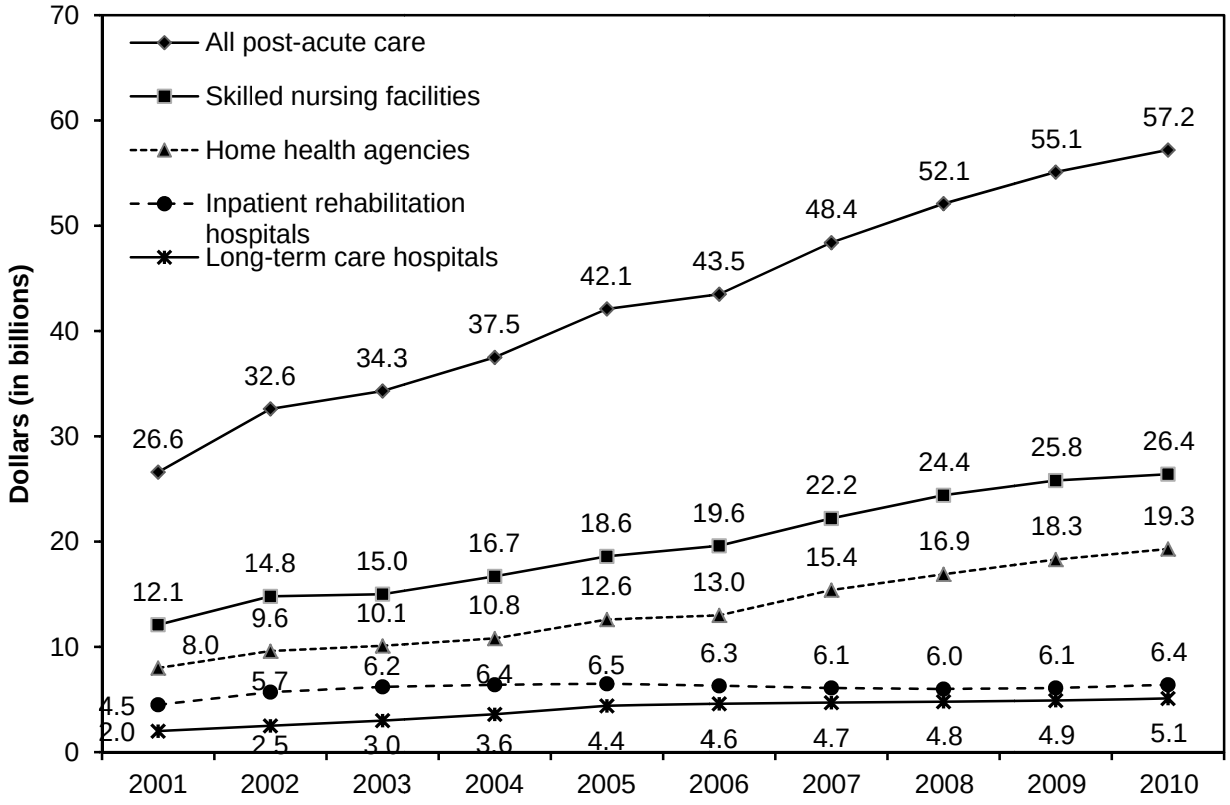
	2002	2003	2004	2005	2006	2007	2008	2009	2010	Average annual percent change 2002–2010	Percent change 2009–2010
Home health agencies	7,057	7,342	7,804	8,314	8,955	9,404	10,036	10,961	11,488	6.5%	4.8%
Inpatient rehabilitation facilities	1,181	1,207	1,221	1,235	1,225	1,202	1,202	1,196	1,179	0.0	–1.4
Long-term care hospitals	297	334	366	392	398	406	424	435	437	4.9	0.5
Skilled nursing facilities	14,794	14,879	14,939	15,001	15,008	15,037	15,031	15,068	15,070	0.2	0.0

Note: The skilled nursing facility count does not include swing beds.

Source: MedPAC analysis of data from certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification's Providing Data Quickly system for 2002–2010 (home health agencies and skilled nursing facilities) and CMS Provider of Service data (inpatient rehabilitation facilities and long-term care hospitals).

- The number of home health agencies has increased substantially since 2002.
- The number of inpatient rehabilitation facilities (rehabilitation hospitals and rehabilitation units) declined slightly in 2010.
- In spite of a moratorium on new long-term care hospitals beginning in October 2007, the number of these facilities has continued to grow.
- The total number of skilled nursing facilities has remained about the same for four years, but the mix of facilities continues to shift from hospital-based to freestanding facilities. Hospital-based facilities make up 6 percent of all facilities, down from almost 11 percent in 2001.

Chart 8-2. Medicare's spending on home health care and skilled nursing facilities fueled growth in FFS post-acute care expenditures



Note: FFS (fee-for-service). These numbers are program spending only and do not include beneficiary copayments.

Source: CMS, Office of the Actuary.

- Increases in fee-for-service (FFS) spending on post-acute care have slowed in part due to expanded enrollment in managed care, whose spending is not included in this chart.
- Despite the slower growth, spending on all post-acute care still grew close to 4 percent between 2009 and 2010, fueled by increases in home health care and skilled nursing facility expenditures.
- FFS spending on inpatient rehabilitation hospitals declined between 2005 and 2008, reflecting policies intended to ensure that patients who do not need this intensity of services are treated in less intensive settings. However, spending on inpatient rehabilitation hospitals increased in 2009 and continued to increase in 2010.

Chart 8-3. Since 2005, the share of Medicare stays and payments going to freestanding SNFs and for-profit SNFs has increased

	Facilities		Medicare-covered stays		Medicare payments	
Type of SNF	2005	2009	2005	2009	2005	2009
All SNFs	100%	100%	100%	100%	100%	100%
Freestanding	92	94	87	92	93	96
Hospital based	8	6	13	8	7	5
Urban	67	70	79	81	81	83
Rural	33	30	21	19	19	17
For profit	68	68	66	69	72	74
Nonprofit	28	26	30	26	25	22
Government	5	5	4	4	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding or missing information about facility characteristics.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files 2005–2009.

- Freestanding skilled nursing facilities (SNFs) made up 94 percent of facilities in 2009.
- Freestanding SNFs treated 92 percent of stays (up 5 percentage points from 2005) and accounted for 96 percent of Medicare payments.
- Between 2005 and 2009, for-profit SNFs' share of Medicare-covered stays increased 3 percentage points and payments increased 2 percentage points.
- Urban SNFs' share of facilities, Medicare-covered stays, and payments increased between 2005 and 2009.

Chart 8-4. Small declines in SNF days and admissions between 2008 and 2009

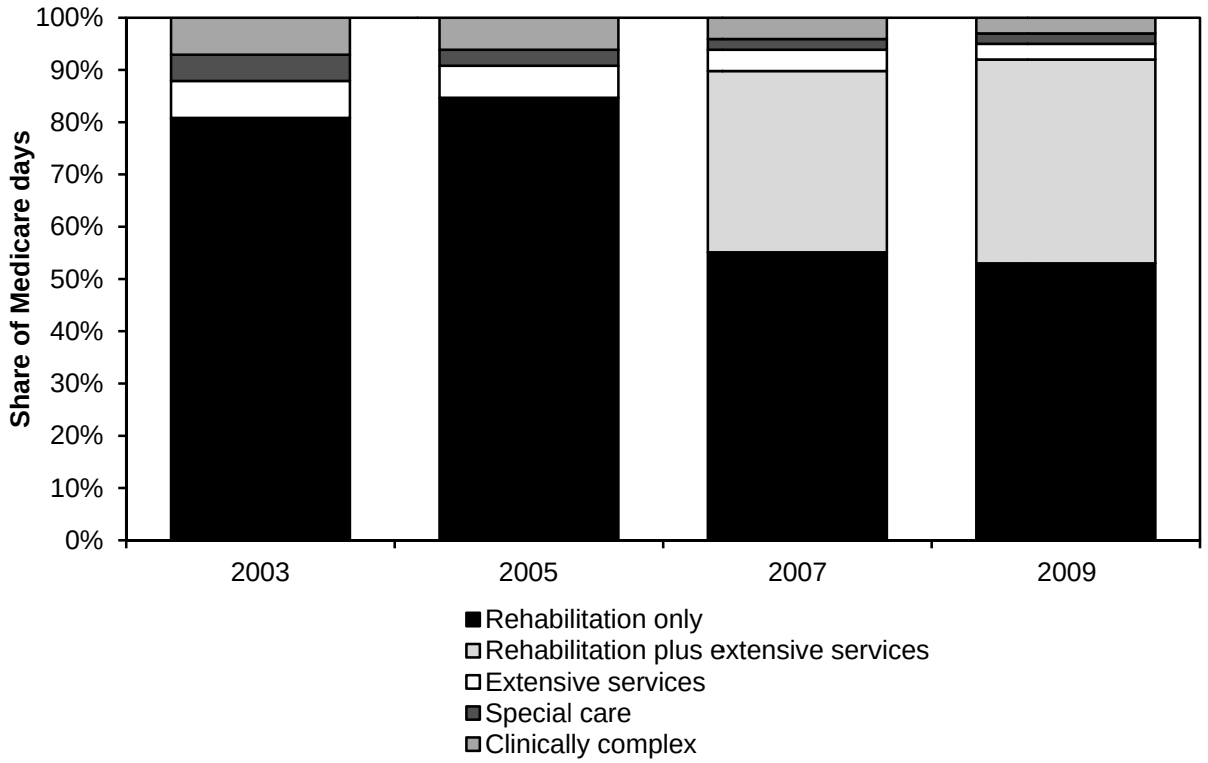
	2007	2008	2009	Change 2008–2009
Volume per 1,000 fee-for-service enrollees				
Covered admissions	72	73	72	–1.6%
Covered days	1,921	1,977	1,963	–0.7
Covered days per admission	26.7	27.0	27.3	0.9

Note: SNF (skilled nursing facility). Data include 50 states and the District of Columbia.

Source: Calendar year data from CMS, Office of Research, Development and Information.

- Between 2008 and 2009, covered days declined, reflecting fewer hospital admissions. A prior hospital stay is required for Medicare coverage.
- Covered admissions declined faster than covered days, resulting in a small increase in covered days per admission.
- Measures are reported on a per fee-for-service enrollee basis because the counts of days and admissions do not include the utilization of beneficiaries enrolled in Medicare Advantage (MA) plans. Because MA enrollment continued to increase, changes in utilization could reflect a smaller pool of users rather than changes in service use by the beneficiaries captured by the data.

Chart 8-5. Case mix in freestanding SNFs shifted toward rehabilitation plus extensive services RUGs and away from other broad RUG categories



Note: SNF (skilled nursing facility), RUG (resource utilization group). The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory services seven days per week, or those who are aphasic or tube fed. The extensive services category includes patients who have received intravenous medications or suctioning in the past 14 days, have required a ventilator or respiratory or tracheostomy care, or have received intravenous feeding within the past 7 days. Days are for freestanding SNFs with valid cost reports.

Source: MedPAC analysis of freestanding SNF cost reports.

- In 2009, rehabilitation resource utilization groups (RUGs) accounted for 92 percent of all Medicare days in freestanding skilled nursing facilities (SNFs). The nine rehabilitation plus extensive services RUGs, the highest payment case-mix groups, made up 39 percent of RUG days (compared with 36 percent in 2008). Within the rehabilitation case-mix groups, days in freestanding SNFs continued to shift toward the highest therapy groups (not shown).

- Some of the growth in total rehabilitation days may be explained by a shift in the site of care from inpatient rehabilitation facilities to SNFs. It also could reflect the payment incentives to furnish the services necessary to get patients classified into higher paying rehabilitation RUGs.

- Between 2003 and 2009, the share of clinically complex and special care days declined from 14 percent to 6 percent. Patients who previously would have been classified into these case-mix groups may have received enough therapy (75 minutes a week) to qualify them for a rehabilitation group.

Chart 8-6. Freestanding SNF Medicare margins have exceeded 10 percent for seven years

Type of SNF	2003	2004	2005	2006	2007	2008	2009
All	10.9%	13.8%	13.1%	13.3%	14.7%	16.6%	18.1%
Urban	10.3	13.2	12.6	13.1	14.6	16.3	18.0
Rural	13.9	16.2	15.2	14.3	15.5	18.0	18.7
For profit	13.4	16.2	15.2	15.8	17.3	19.1	20.3
Nonprofit	1.3	3.6	4.6	3.5	4.2	7.1	9.5
Government*	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: SNF (skilled nursing facility), N/A (not applicable).
*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of freestanding SNF cost reports.

- Although aggregate Medicare margins for freestanding skilled nursing facilities (SNFs) have varied over the past 7 years, they have exceeded 10 percent every year since 2001 (early years not shown).
- Aggregate Medicare margins increased from 2008 to 2009 due to costs per day growing more slowly than payments per day. The growth in payments reflected the increased share of days classified into the highest paying resource utilization groups.
- Examining the distribution of 2009 margins, one-half of freestanding SNFs had margins of 18.7 percent or more. One-quarter had Medicare margins at or below 8.8 percent and one-quarter had margins of 26.7 percent or higher.

Chart 8-7. Freestanding SNFs with relatively low costs and high quality maintained high Medicare margins

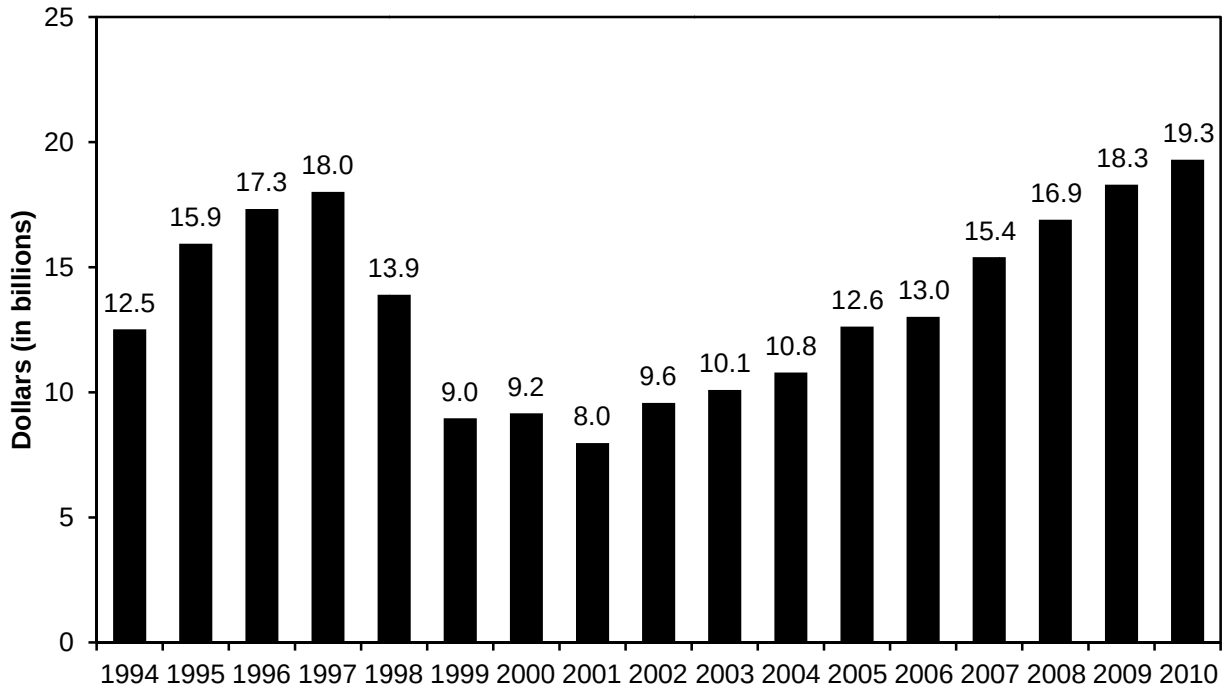
Characteristic	SNFs with relatively low costs and good quality (9 percent)	Other SNFs
Performance in 2008		
Relative* community discharge rate	1.29	1.0
Relative* rehospitalization rate	0.84	1.0
Relative* cost per day	0.90	1.0
Median length of stay	35 days	41 days
Medicare margin	21.8%	17.4%
Performance in 2009		
Relative* cost per day	0.890	1.0
Median length of stay	35 days	40 days
Medicare margin	21.8%	18.3%
Total margin	5.3%	3.9%
Medicaid share of facility days	58%	62%

Note: SNF (skilled nursing facility). SNFs with relatively low costs and good quality were those in the lowest third of the distribution of cost per day, in the top third for one quality measure, and not in the bottom third for the other quality measure. Costs per day were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted community discharge and rehospitalization for five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) within 100 days of hospital discharge. Increases in rates of discharge to the community indicate improved quality; increases in rehospitalization rates for the five conditions indicate worsening quality. Quality measures were calculated for all facilities with more than 25 stays.
*Measures are relative to the national average.

Source: MedPAC analysis of quality measures for 2005–2008 and Medicare cost report data for 2005–2009.

- Freestanding skilled nursing facilities (SNFs) can have relatively low costs and provide good quality of care while maintaining high margins.
- In 2008, compared with other SNFs, relatively efficient SNFs had community discharge rates that were 29 percent higher and rehospitalization rates that were 16 percent lower.
- In 2009, relatively efficient SNFs had costs per day that were 11 percent lower and shorter lengths of stay compared with other SNFs. Relatively efficient SNFs had Medicare margins in 2009 of 21.8 percent compared with a median margin for other SNFs of 18.3 percent.
- Relatively efficient SNFs were more likely to be located in a rural area and more likely to be nonprofit than other SNFs.

Chart 8-8. Spending for home health care, 1994–2010



Source: CMS, Office of the Actuary, 2011.

- Medicare home health care spending grew at an average annual rate of 20 percent from 1992 to 1997. During that period, the payment system was cost based. Eligibility had been loosened just before this period, and enforcing the program's standards became more difficult. Providers delivering billing for fraudulent or uncovered services also were a significant factor in the increase in expenditures.

- Spending began to fall after 1997, concurrent with the introduction of the interim payment system (IPS) based on costs with limits, tighter eligibility, and increased scrutiny from the Office of Inspector General.

- In October 2000, the prospective payment system (PPS) replaced the IPS. At the same time, eligibility for the benefit broadened slightly. Enforcement of the Medicare program's integrity standards continues at the regional home health intermediaries and state survey and certification agencies.

- Home health care has risen rapidly under PPS. Spending has risen by about 10 percent a year between 2001 and 2009.

Chart 8-9. Provision of home health care changed after the prospective payment system started

				Percent change	
	1997	2001	2009	1997–2001	2001–2009
Number of visits (in millions)	258	74	130	–72%	76%
Visit type (percent of total)					
Home health aide	48%	25%	16%		
Skilled nursing	41	50	55		
Therapy	10	24	28		
Medical social services	1	1	1		
Visits per home health patient	73	33	39	–55	20

Note: The prospective payment system began in October 2000.

Source: Home health Standard Analytic File; Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 2002.

- The types and amount of home health care services that beneficiaries receive have changed. In 1997 home health aide services were the most frequently provided visit type, and beneficiaries who used home health care received an average of 73 visits.

- CMS began to phase in the interim payment system in October 1997 to stem the rise in spending for home health services and implemented a prospective payment system (PPS) in 2000 (see Chart 8-8). By 2001, total visits dropped by 72 percent, and average visits per user had dropped to 33. The increase in visits per user between 2001 and 2009 reflects home health users getting more episodes. The mix of services changed as well, with skilled nursing and therapy visits now accounting for over 80 percent of all services. Since PPS was implemented, the number of users and episodes has risen rapidly (see Chart 8-10).

Chart 8-10. Trends in provision of home health care

	2002	2005	2009	Average annual percent change 2002–2009
Number of users (in millions)	2.5	3.0	3.3	3.9%
Percent of beneficiaries who used home health	7.2%	8.1%	9.4%	3.8
Episodes (in millions)	4.1	5.2	6.6	6.9
Episodes per home health patient	1.6	1.8	2.0	4.5
Visits per home health patient	31	32	39	3.7
Average payment per episode	$2,329	$2,470	$2,879	3.1

Source: MedPAC analysis of the home health Standard Analytic File.

- Under the prospective payment system, in effect since 2000, the number of users and the number of episodes have risen significantly. In 2009, more than 3 million beneficiaries used the home health benefit.
- The number of home health episodes increased rapidly from 2002 to 2009. The number of beneficiaries using home health has also increased since 2002 but at a lower rate than the growth in episodes.
- The number of visits per home health patient increased from 31 in 2002 to 39 in 2009. This increase is primarily due to an increase in the number of home health episodes per patient.

Chart 8-11. Margins for freestanding home health agencies

	2008	2009	Percent of agencies 2009
All	17.0%	17.7%	100%
Geography			
Urban	17.3	17.9	83
Rural	16.0	16.6	17
Type of control			
For profit	18.6	18.7	84
Nonprofit	12.3	14.4	11
Volume quintile			
First	9.0	8.9	20
Second	9.3	8.7	20
Third	13.3	12.6	20
Fourth	16.0	16.5	20
Fifth	18.9	20.1	20

Source: MedPAC analysis of 2008–2009 Cost Report files.

- In 2009, about 78 percent of agencies had positive margins (not shown in chart). These estimated margins indicate that Medicare's payments are above the costs of providing services to Medicare beneficiaries for both rural and urban home health agencies (HHAs).
- These margins are for freestanding HHAs, which composed about 85 percent of all HHAs in 2009. HHAs are also based in hospitals and other facilities.
- HHAs that served mostly urban patients in 2009 had a weighted average margin of 17.9 percent; those that served mostly rural patients had a weighted average margin of 16.6 percent. The 2009 margin is consistent with the historically high margins the home health industry has experienced under the prospective payment system. The weighted average margin from 2001 to 2008 was 17.5 percent, indicating that most agencies have been paid well in excess of their costs under prospective payment.
- For-profit agencies in 2009 had a weighted average margin of 18.7 percent, and nonprofit agencies had a weighted average margin of 14.4 percent.
- Agencies that serve more patients have higher margins. The agencies in the lowest volume quintile in 2009 have a weighted average margin of 8.9 percent, while those in the highest quintile have a weighted average margin of 20.1 percent.

Chart 8-12. Most common types of inpatient rehabilitation facility cases, 2010

Type of case	Share of cases
Stroke	20.5%
Hip fracture	14.4
Major joint replacement	11.2
Debility	9.9
Neurological	9.7
Brain injury	7.3
Other orthopedic	6.5
Cardiac conditions	5.0
Spinal cord injury	4.3
Other	11.3

Note: Other includes conditions such as amputations, major multiple trauma, and pain syndrome. Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS (January through June of 2010).

- In 2010, the most frequent diagnosis for Medicare patients in inpatient rehabilitation facilities (IRFs) was stroke, representing close to 21 percent of cases, up from 2004, when stroke represented fewer than 17 percent of cases.

- Major joint replacement cases represented just over 11 percent of IRF admissions in 2010, down from 24 percent of cases in 2004, when major joint replacement was the most common IRF Medicare case type.

Chart 8-13. Volume of IRF FFS patients remained stable in 2009, after declining from 2004 to 2007

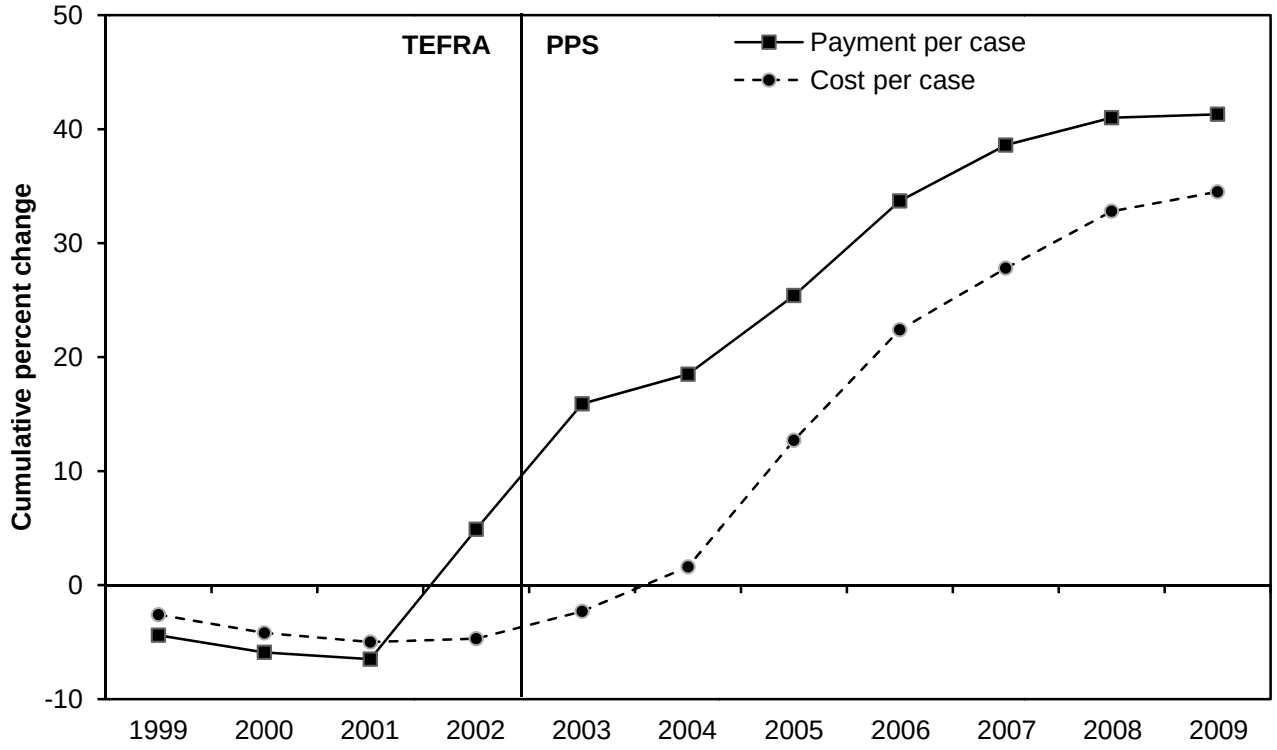
	2004	2007	2008	2009	Average annual percent change 2004–2008	Percent change 2008–2009
Number of IRF cases	455,000	364,000	356,000	361,000	–6.0%	1.5%
Unique patients per 10,000 FFS beneficiaries	113.2	93.2	91.5	92.9	–5.2	1.5
Payment per case	$13,275	$16,143	$16,649	$16,568	5.8	-0.5
Medicare spending (in billions)	$6.43	$6.08	$5.96	$6.07	–1.9	1.8
Average length of stay (in days)	12.7	13.2	13.3	13.1	1.2	–1.5

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Numbers of cases reflect Medicare FFS utilization only.

Source: MedPAC analysis of MedPAR data from CMS. Total Medicare spending for IRF services from CMS Office of the Actuary.

- Inpatient rehabilitation facility (IRF) volume is measured by the number of IRF cases and the number of unique patients per 10,000 beneficiaries, which controls for changes in fee-for-service (FFS) enrollment.
- IRF volume declined after 2004 when enforcement of the compliance threshold (60 percent rule) was renewed.
- Medicare FFS spending on IRFs declined between 2004 and 2008 as more IRFs complied with the 60 percent rule and more Medicare beneficiaries enrolled in Medicare Advantage plans.
- In 2009, volume remained relatively stable, with the number of cases increasing from 2008 by 1.5 percent. The increase in the number of cases was due to an increase in both the number of unique beneficiaries receiving IRF care and an increase in the number of beneficiaries with more than one IRF stay in a year.
- IRF Medicare payments per case and average length of stay have increased since 2004, consistent with increasing average case mix of IRF patients. However, the average FFS payment per case declined by half a percent between 2008 and 2009 because payments in 2009 were held at 2007 levels.

Chart 8-14. Overall IRFs' payments per case have risen faster than costs, post-PPS



Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982). Data are from consistent two-year cohorts of IRFs. Costs are not adjusted for changes in case mix.

Source: MedPAC analysis of cost report data from CMS.

- Medicare costs and payments per case increased at similar rates before implementation of the prospective payment system (PPS) in 2002 as inpatient rehabilitation facilities (IRFs) received cost-based reimbursement under the Tax Equity and Fiscal Responsibility Act of 1982.
- Since implementation of the PPS, overall Medicare payments per case have increased faster than costs, even when costs per case grew rapidly between 2004 and 2006 as a result of enforcement of the compliance threshold.
- These trends in Medicare per case payments and costs are reflected in IRFs' Medicare margins, shown in Chart 8-15.

Chart 8-15. Inpatient rehabilitation facilities' Medicare margin by type, 2001–2009

	TEFRA	PPS					
	2001	2002	2003	2005	2007	2008	2009
All IRFs	1.5%	10.9%	17.7%	13.3%	11.9%	9.6%	8.4%
Hospital based	1.5	6.1	14.7	9.3	8.1	4.4	0.5
Freestanding	1.5	18.5	22.9	20.7	18.5	18.2	20.1
Urban	1.5	11.3	18.2	13.5	12.0	9.8	8.5
Rural	1.1	5.9	12.5	12.0	10.2	7.9	6.6
Nonprofit	1.6	6.5	14.5	10.2	9.6	5.6	2.3
For profit	1.2	18.7	23.9	19.8	16.9	17.0	19.1

Note: TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system), IRF (inpatient rehabilitation facility).

Source: MedPAC analysis of cost report data from CMS.

- The aggregate Medicare margin increased rapidly during the first two years of the inpatient rehabilitation facility (IRF) prospective payment system (PPS). Aggregate margins rose from just under 2 percent in 2001 to almost 18 percent in 2003.
- From 2003 to 2009, margins declined but remained high. This decline was largely due to reductions in patient volume over this time period that resulted in fewer patients among whom to distribute fixed costs. The 2007 to 2009 margin decrease was mainly a result of a zero update to the base rates for half of 2008 and for all of 2009 that resulted in Medicare payment rates remaining at 2007 levels.
- Freestanding and for-profit IRFs had substantially higher aggregate Medicare margins than hospital-based and nonprofit IRFs, continuing a trend that began with implementation of the IRF PPS in 2002.

Chart 8-16. Top MS–LTC–DRGs made up more than half of LTCH discharges in 2009

MS–LTC–DRG	Description	Discharges	Percentage
207	Respiratory system diagnosis with ventilator support 96+ hours	15,378	11.7%
189	Pulmonary edema & respiratory failure	9,438	7.2
871	Septicemia or severe sepsis without ventilator support 96+ hours with MCC	6,857	5.2
177	Respiratory infections & inflammations with MCC	4,690	3.6
592	Skin ulcers with MCC	3,913	3.0
949	Aftercare with CC/MCC	3,576	2.7
208	Respiratory system diagnosis with ventilator support <96 hours	2,729	2.1
190	Chronic obstructive pulmonary disease with MCC	2,687	2.0
193	Simple pneumonia & pleurisy with MCC	2,613	2.0
593	Skin ulcers with CC	2,103	1.6
539	Osteomyelitis with MCC	2,102	1.6
573	Skin graft and/or debridement for skin ulcer or cellulitis with MCC	1,984	1.5
559	Aftercare, musculoskeletal system & connective tissue with MCC	1,971	1.5
862	Postoperative & post-traumatic infections with MCC	1,953	1.5
291	Heart failure & shock with MCC	1,860	1.4
166	Other respiratory system OR procedures with MCC	1,810	1.4
178	Respiratory infections & inflammations with CC	1,797	1.4
682	Renal failure with MCC	1,783	1.4
314	Other circulatory system diagnosis with MCC	1,748	1.3
919	Complications of treatment with MCC	1,747	1.3
	Top 20 MS–LTC–DRGs	72,739	55.3
	Total	131,446	100.0

Note: MS–LTC–DRG (Medicare severity–long-term care–diagnosis related group), LTCH (long-term care hospital), MCC (major complication or comorbidity), CC (complication or comorbidity), OR (operating room). MS–LTC–DRGs are the case-mix system for these facilities. Columns may not sum due to rounding.

Source: MedPAC analysis of MedPAR data from CMS.

- Cases in long-term care hospitals (LTCHs) are concentrated in a relatively small number of Medicare severity–long-term care–diagnosis related groups (MS–LTC–DRGs). In 2009, the top 20 MS–LTC–DRGs accounted for more than half of all cases.

- The most frequent diagnosis in LTCHs in 2009 was respiratory diagnosis with ventilator support for more than 96 hours. Eight of the top 20 diagnoses, representing 31 percent of all cases, were respiratory conditions.

Chart 8-17. LTCH spending per FFS beneficiary has increased under PPS

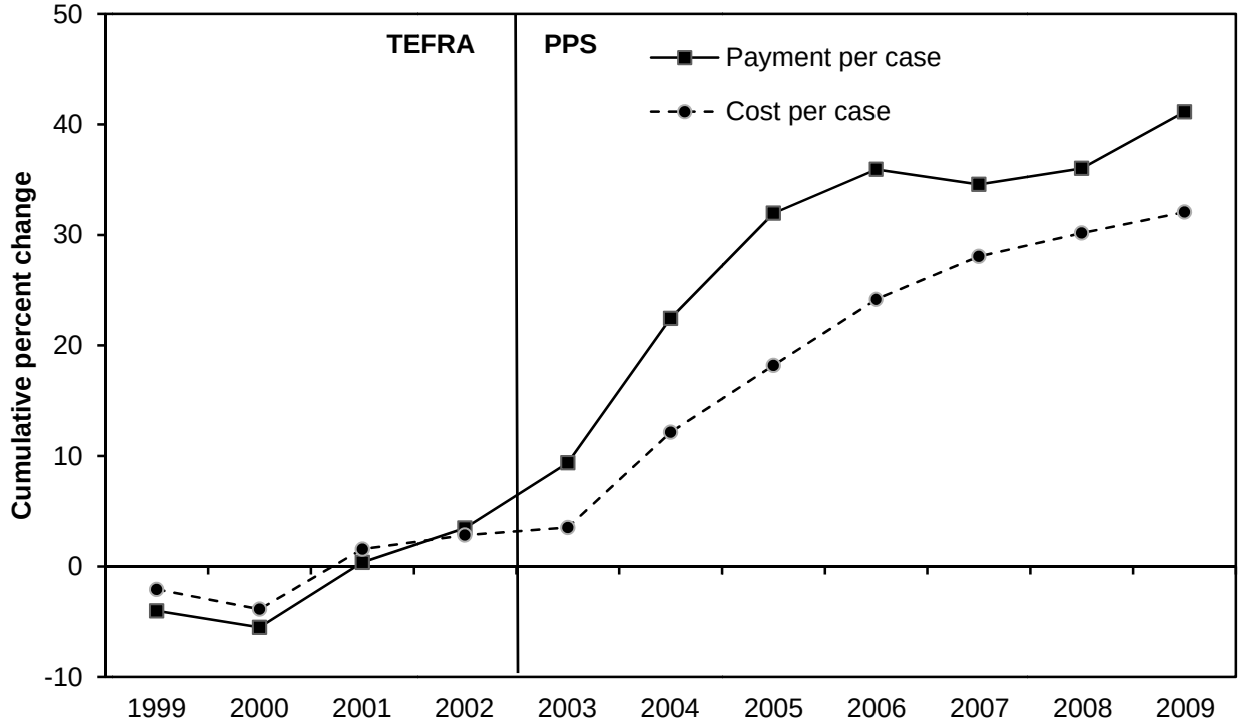
						Average annual change		
	2003	2005	2007	2008	2009	2003–2005	2005–2008	2008–2009
Cases	110,396	134,003	129,202	130,869	131,446	10.2%	–0.8%	0.4%
Cases per 10,000 FFS beneficiaries	30.8	36.4	36.3	37.0	37.4	8.8	0.6	0.9
Spending per FFS beneficiary	$75.2	$122.2	$126.5	$130.4	$139.3	27.5	2.2	6.8
Payment per case	$24,758	$33,658	$34,769	$35,200	$37,465	16.6	1.5	6.4
Length of stay (in days)	28.8	28.2	26.9	26.7	26.4	–1.0	–1.8	–1.1

Note: LTCH (long-term care hospital), FFS (fee-for-service), PPS (prospective payment system). Growth in per FFS cases and spending was slowed in 2006 and 2007 by large increases in the number of Medicare Advantage enrollees, whose long-term care hospital use and spending are not included in these totals.

Source: MedPAC analysis of MedPAR data from CMS.

- Between 2008 and 2009, Medicare spending per fee-for-service beneficiary rose 6.8 percent, much more than the rate of growth in the number of cases.

Chart 8-18. LTCHs' per case payment rose more quickly than costs in 2009



Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Data are from consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Payment per case increased rapidly after the prospective payment system was implemented, climbing an average 16.6 percent per year between 2003 and 2005. Cost per case also increased rapidly during this period, albeit at a somewhat slower pace.

- Between 2005 and 2008, growth in cost per case outpaced that for payments, as regulatory changes to Medicare's payment policies for long-term care hospitals slowed growth in payment per case to an average of 1.5 percent per year.

- After the Congress delayed implementation of some of CMS's recent regulations, payments per case climbed 6.4 percent between 2008 and 2009. Cost per case, however, rose less than 2 percent.

Chart 8-19. LTCHs' Medicare margins by type of facility

Type of LTCH	Share of discharges (2009)	TEFRA 2002	PPS 2003	2004	2005	2006	2007	2008	2009
All	100%	–0.1%	5.2%	9.0%	11.9%	9.7%	4.8%	3.5%	5.7%
Urban	96	–0.1	5.2	9.2	11.9	9.9	5.0	3.8	6.0
Rural	4	–0.5	4.5	2.6	10.1	4.9	–0.7	–2.8	–3.7
Freestanding	70	0.1	5.6	8.4	11.3	9.3	4.3	3.1	4.9
Hospital within hospital	31	–0.5	4.2	10.6	13.1	10.8	5.8	4.4	7.6
Nonprofit	16	0.1	1.9	6.9	9.0	6.6	1.3	–2.4	–0.2
For profit	83	–0.1	6.3	10.0	13.1	10.9	5.9	5.1	7.3

Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Columns may not sum to 100 percent due to rounding or missing data. Government-owned providers operate in a different context from other providers, so their margins are not reported here.

Source: MedPAC analysis of cost report data from CMS.

- After implementation of the prospective payment system, long-term care hospitals' (LTCHs') Medicare margins increased rapidly, from 5.2 percent in 2003 to 11.9 percent in 2005. Margins then fell as growth in payments per case leveled off. In 2009, however, LTCH margins began to increase again, reaching 5.7 percent.

- Financial performance in 2009 varied across LTCHs. The aggregate Medicare margin for for-profit LTCHs (which accounted for 83 percent of all Medicare discharges from LTCHs) was 7.3 percent, compared with –0.2 percent for nonprofit facilities (which accounted for 16 percent of all Medicare LTCH discharges). Rural LTCHs' aggregate margin was –3.7 percent, compared with 6.0 percent for their urban counterparts. Rural providers account for about 4 percent of all LTCHs, caring for a smaller volume of patients on average, which may result in poorer economies of scale.

Chart 8-20. LTCHs in the top quartile of Medicare margins in 2009 had much lower costs

Characteristics	High-margin LTCHs	Low-margin LTCHs
Mean total discharges (all payers)	533	410
Medicare patient share	66%	64%
Average length of stay (in days)	26	27
Mean per discharge:		
Standardized costs	$26,123	$37,647
Medicare payment	$38,635	$37,094
High-cost outlier payments	$1,455	$3,887
Share of:		
Cases that are SSOs	27%	35%
Medicare cases from primary-referring ACH	39	38
LTCHs that are for-profit	92	70

Note: LTCH (long-term care hospital), SSO (short-stay outlier), ACH (acute care hospital). Includes only established LTCHs—those that filed valid cost reports in both 2008 and 2009. High-margin LTCHs were in the top 25 percent of the distribution of Medicare margins. Low-margin LTCHs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs have been adjusted for differences in case mix and area wages. Average primary referring ACH referral share indicates the mean share of patients who are referred to LTCHs from each LTCH's primary referring ACH.

Source: MedPAC analysis of LTCH cost reports and MedPAR data from CMS.

- A quarter of all long-term care hospitals (LTCHs) had margins in excess of 15.7 percent, while another quarter had margins below –3.9 percent.

- Lower per discharge costs, rather than higher payments, drove the differences in financial performance between LTCHs with the lowest and highest Medicare margins. Low-margin LTCHs had standardized costs per discharge that were almost 50 percent higher than high-margin LTCHs ($37,647 vs. $26,123).

- High-cost outlier payments per discharge for low-margin LTCHs were more than double those of high-margin LTCHs ($3,887 vs. $1,455). At the same time, short-stay outliers made up a larger share of low-margin LTCHs' cases. Low-margin LTCHs thus cared for disproportionate shares of patients who are high-cost outliers and patients who have shorter stays. Both types of patients can have a negative effect on LTCHs' margins. LTCHs lose money on high-cost outlier cases since, by definition, they generate costs that exceed payments. Payments for short-stay outliers cannot be more than 100 percent of the costs of the case.

- Low-margin LTCHs service fewer patients overall. Poorer economies of scale may therefore affect low-margin LTCHs' costs.

- Low-margin LTCHs were far less likely to be for profit than were their high-margin counterparts.

Web links. Post-acute care

Skilled nursing facilities

- Chapter 7 of MedPAC's March 2011 Report to the Congress provides information about the supply, quality, service use, and Medicare margins for skilled nursing facilities. Chapter 7 of MedPAC's June 2008 Report to the Congress provides information about alternative designs for Medicare's prospective payment system that would more accurately pay providers for their skilled nursing facility services. *Medicare payment basics: Skilled nursing facility payment system* provides a description of how Medicare pays for skilled nursing facility care.

  http://www.medpac.gov/chapters/Mar11_Ch07.pdf

  http://www.medpac.gov/chapters/Jun08_Ch07.pdf

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_SNF.pdf

- The official Medicare website provides information on skilled nursing facilities, including the payment system and other related issues.

  http://www.cms.gov/SNFPPS/

Home health services

- Chapter 8 of MedPAC's March 2011 Report to the Congress, Chapter 2E of MedPAC's March 2009 Report to the Congress, Chapter 4 of MedPAC's June 2007 Report to the Congress, and Chapter 5 of MedPAC's June 2006 Report to the Congress provide information on home health services. *Medicare payment basics: Home health care services payment system* provides a description of how Medicare pays for home health care.

  http://www.medpac.gov/chapters/Mar11_Ch08.pdf

  http://www.medpac.gov/chapters/Mar09_Ch02e.pdf

  http://www.medpac.gov/chapters/Jun07_Ch04.pdf

  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch05.pdf

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_HHA.pdf

- The official Medicare website provides information on the quality of home health care and additional information on new policies, statistics, and research as well as information on home health spending and use of services.

  http://www.cms.gov/HomeHealthPPS/

Inpatient rehabilitation facilities

- Chapter 9 of MedPAC's March 2011 Report to the Congress provides information on inpatient rehabilitation facilities. *Medicare payment basics: Rehabilitation facilities (inpatient) payment system* provides a description of how Medicare pays for inpatient rehabilitation facility services.

  http://www.medpac.gov/chapters/Mar11_Ch09.pdf

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_IRF.pdf

- CMS provides information on the inpatient rehabilitation facility prospective payment system.

  http://www.cms.gov/InpatientRehabFacPPS/

Long-term care hospitals

- Chapter 10 of MedPAC's March 2011 Report to the Congress provides information on long-term care hospitals. *Medicare payment basics: Long-term care hospital services payment system* provides a description of how Medicare pays for long-term care hospital services.

  http://www.medpac.gov/chapters/Mar11_Ch10.pdf

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_LTCH.pdf

- CMS also provides information on long-term care hospitals, including the long-term care hospital prospective payment system.

  http://www.cms.gov/LongTermCareHospitalPPS/